Crisis Bed Development Work Group
July 10, 2006 1:00 p.m. – 4:00 p.m.
Clara Martin Center, Randolph, Vermont

Next meeting: July 28, 2006 9:00 – 11:00 a.m. Location: Clara Martin Center, Randolph, Vermont

Present:	Jeff Rothenberg, CMC Sandy Smith, CSAC John Stewart, RMHS Anne Donahue, Counterpoint Sheryl Bellman, HCHS (by phone)
Staff:	Judy Rosenstreich, VDH/DMH Cindy Thomas, VDH/DMH

STATUS OF DATA COLLECTION EFFORTS

The group took stock of where we are at in terms of collecting information from CRT directors, Emergency Services directors, and representatives of Designated Hospitals. Jeff distributed the survey results that are in so far. Judy will survey the Designated Hospitals, using the questions that Anne developed.

- CRT directors were asked to review six months of CRT hospitalization data.
- Emergency Services directors were asked to review six months of screenings resulting in an adult being hospitalized.

Discussion centered around how to use the data to arrive at the core recommendations of where and what type of crisis bed programs are needed. Whatever our recommendations for improving access to crisis beds, the new capacities will become part of the developing clinical care management system. Jeff offered that a crisis bed program could be developed and operated by a care management entity or by a designated agency. More agencies appear to be interested in having a crisis bed program than the number of programs we could develop under the Futures Plan. Sheryl asked who might the employees work for if the crisis bed program was run by a "care management entity."

Anne presented a chart that she was in the process of developing that listed each of the Designated Agency catchment areas, their populations, designated or community hospitals, crisis beds, awake staff/24 hours, community care home beds, and other data elements that could help to identify the gaps in access to crisis beds. Jeff agreed that it would be beneficial to complete this spread sheet.

ACCESSIBILITY

The group discussed the need for and definition of *access*. It was pointed out that from the consumer perspective a critical aspect is geographic proximity to a crisis bed program. For a one- to two-day stay in a crisis bed, it should not be far away from home. By the same token, if someone would rather go to a crisis bed than to a hospital, we should not preclude the crisis bed only because it's further away.

Anne sees crisis beds as being the most locally-based services as opposed to a community recovery program that is regionally based.

Jeff's interactions in obtaining responses to the two surveys has made him aware of different levels of interest among the agencies. Building a two-bed program may be more feasible for a local agency to do on their own. A four-to-five bed program is more apt to serve a region.

Sheryl added that sometimes beds are used for other things, i.e., used to help someone having a difficult time instead of sending them home. In such cases, crisis beds may not actually be for hospital diversion. Anne commented that according to the Futures Plan the new crisis bed capacity is supposed to be strictly for hospital diversion.

LOCAL AGENCY NEEDS ASSESSMENT

Anne stated that the local agency has the best sense of what they need, the type of program, the most appropriate model given the experience of that agency. In areas that we have identified the greatest gap, we can ask those agencies what type of program would best fill the gap.

ACHIEVING STATEWIDE ACCESS

The group's ultimate recommendation should be grounded in what is needed to assure access to this core service. Every area of the State needs access for the system to work and to reduce hospital admissions. The Health Resource Allocation Plan (HRAP) refers to travel distances as a component of access to health care. This stimulated discussion about the practicality of recommending access to a crisis bed program reachable within 30 minutes. Availability of a crisis bed in twelve locations, minimally, would be required to meet this standard: St. Albans, Burlington, Middlebury, Rutland, Bennington, Morrisville, Newport, Barre, St. Johnsbury, White River Junction, Bellows Falls, and Brattleboro. Interestingly, these locations match existing healthcare infrastructure in the state, namely, the community hospitals.

Given this network of community hospitals and their potential to augment crisis bed program enhancements, the group contemplated beginning a dialogue with the community hospitals about making available one observation bed in each of the hospitals

without psychiatric units. The designated hospitals already have this capacity. It also was mentioned that Bea Grause, president and chief executive of the Vermont Association of Hospitals and Health Systems, serves on the Futures Advisory Committee. Given the plan to close the state hospital, it may be apropos to begin a conversation about this concept among the community hospitals. If this need was identified in the HRAP, community hospitals could ultimately be required to make available a bed for psychiatry just as they do for every other illness. Jeff suggested that one possible route toward this goal is through a pilot program.

PUBLIC INEBRIATE PROGRAM

There was a brief discussion of the cost per night of taking care of someone incapacitated by alcohol and/or substance abuse. Jeff has had some dialogue with Nick Nichols and will invite him to participate in the work group. In his recommendations, former AHS Secretary Charlie Smith asked for consideration of some allocation of crisis bed resources for this purpose.

NEXT MEETINGS

July 28	9:00 a.m. – 11:00 a.m.	Clara Martin Center, Randolph
August 23	1:00 p.m. – 4:00 p.m.	(possible visit to Alternatives, Bellows Falls TO BE DETERMINED)
September 13	1:00 p.m. – 3:00 p.m.	Clara Martin Center, Randolph

The meeting adjourned at 3:30 p.m.

SUBMITTED BY: Judy Rosenstreich
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